Ethics issues in mounting screening for women: Participants’ perspectives of compulsory and voluntary screening in Kenya

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Abstract:

Introduction:
Screening asymptomatic individuals to detect early unapparent conditions is an important public health intervention strategy. It may be designed to be compulsory or voluntary. Given the diverse sociocultural settings as well as the domains and perspectives of public health ethics analysis ways to resolve potential ethical problems may be challenging. Frameworks of ethical analysis traditionally consider nature of the activity itself (deontological) and the consequences expected (teleological); other perspectives include prescribed civil liberties, obligations and equity. Participants’ perspectives provide the necessary contextual information that clarifies mundane community concerns. In Kenya, the national public health policy embodies social justice, equity, human rights and quality well-being as key operational elements. With this background, understanding client perspectives is essential in mounting screening programs.

Methods and discussion:
Focus group discussions with female clients screened for syphilis and cancer of the cervix were conducted to elicit their perspectives of compulsory and voluntary screening. The discussions were audiotaped, transcribed and thematic content analysis performed manually to explore emerging ethics issues. The results indicate that participants were more concerned about the benefits of the procedure and whether their dignity is respected than the compulsoriness of screening

Conclusions
The context for mounting screening as a public health intervention and attendant ethical issues may be more complex than hitherto perceived. Interpreting emerging ethics issues in screening requires more nuanced considerations of individuals’ contextual experiences since these may be contradictory to the policy position. In considering mounting screening for Syphilis and cervical cancer as a public heal intervention, the community interests and perspectives should be inculcated into the program. Lack of information on procedures may influence adversely the demand for screening services by the individuals at risk or the community as a collective agent.

Key words: Ethics, public health, compulsory screening, voluntary screening, participants’ perspectives.
Introduction
Screening as a public health strategy entails early detection of disease or its precursors in asymptomatic populations deemed to be at risk. Its key objectives include detecting diseases early when treatment is more cost-effective; identifying disease predisposing factors and appropriate management of identified risk factors. It may be mounted as voluntary or mandatory national program with a long-term aim of reducing morbidity and mortality. The underlying ethical constructs applicable to screening population for disease are diverse. Applicable principles are largely based on: (i) duty of the state to provide satisfactory opportunities for people’s health while respecting and balancing their civil and personal liberties [stewardship principle]; (ii) maximizing utility (in terms of net benefits as key outcomes) [Paternalism principle]; (iii) minimizing harm [the harm principle]; (iv) protecting the incompetent or most vulnerable populations [best interest principle], and (v) equity [distributive / proportionality principle]. The rationale for screening women for Syphilis and cancer of the cervix is premised on these principles. There is need to understand how patients experience screening procedures/services. This study sought to: i) elicit ethical issues in screening from participants’ perspectives and; ii) highlight the public health context in Kenya. The results highlight local interpretative notions useful for progressive implementation decisions.

Public health and ethics frameworks in Kenya
Since independence the public health policy goals have consistently focused on elimination of disease; community participation; promotion of effective, accessible, acceptable and affordable quality health services and enhanced regulatory capacity of Ministry of Health (MoH). These commitments demonstrate state aspirations, obligations and operational domains for achieving equitable and effective public health services. The health sector strategic plans aim to redress inequities from systematic disadvantages while strengthening service coverage and effectiveness. The fundamental challenge remains how to achieve these aspirations while minimizing potential harms to individuals or communities.

The national health guidelines have progressively adopted a life-cycle, rights-based essential health care, presuming the right to ‘the highest attainable standard of health’ for everyone. The core values of a rights-based approach include fairness, respect, equality, dignity and autonomy (FREDA) as well as accountability and community participation. Integrated screening is a core component of the national reproductive health program whose aim is to improve maternal health; reduce neonatal / child mortality and morbidity; reduce the spread of HIV/AIDS and promote empowerment of women. The main outlets for these services include the MCH/FP clinics, outpatient gynaecology/urology clinics, maternity units and comprehensive care clinics.
Frameworks for screening Syphilis and cancer of the cervix in Kenya.
The national policies and regulation specifically related to screening syphilis and cancer of the cervix are still nascent. The regulations, policies and guidelines have progressively evolved over the last four decades in response to emerging international principles of reproductive health care. The Public Health Act of 1986 (Cap 242) is the main regulatory instrument for health services in Kenya. It provides the legal framework for screening for Syphilis in Kenya. The HIV and AIDS Prevention and Control Act, 2006 and the Children’s Act of 2001 provide additional instruments access to health care; contexts for informed consent, privacy, confidentiality, information, education and communication. Chapters 45 (a) – (c), 48 and 51 of the Public Health Act gives the Medical Officer of Health discretionary powers to identify localities of high disease prevalence and order for medical examination, diagnosis and treatment of populations most at risk. Failure to submit to such examination and/or treatment is an offence. Notification of Syphilis upon diagnosis is mandatory. A medical practitioner is obligated to notify client or her partner(s) once the disease is diagnosed and to provide written instructions about the condition, appropriate education and counseling and ensure strict privacy and confidentiality of their medical records. Similarly, the clients or parents/guardians of children are required to submit themselves or their children for treatment and follow up until cured of the infection. Intentional transmission of the disease under this act is an offence.

The referent strategic documents that support current operational framework for reproductive health are: the National Health Sector Strategic Plan 2008-2010 (NHSSP II); the respective strategic plans of Ministry of Public Health and Sanitation (MOPHS) and Ministry of Medical Services (MOMS); the National Reproductive Health Policy (NRHP), 2007; Norms and Standards for Health Service Delivery (2006) and; the Kenya Essential Package for Health (KEPH). The Safe Motherhood Initiative, launched in Kenya in 1987 was aimed at reducing maternal morbidity and mortality through comprehensive preconception care, antenatal and safe delivery services. It stipulates that clients should be accorded essential education and care to ensure prevention, early detection and prompt effective management of diseases or related complications. In 1989, tests for hemoglobin, blood group, rhesus types and serology for Syphilis and HIV were integrated into the antenatal care services as the basic investigations to be carried out during pregnancy. Additionally, antenatal mothers are required to make a minimum of four clinic visits before term.

The Program of Action of the International Conference on Population and Development (ICPD) held in Cairo, Egypt in 1994 occasioned simultaneous policy shift towards comprehensive rights-based Sexual and Reproductive Health (SRH). The sessional paper Number 1 of 2000 on population policy and the first National Reproductive Health Policy adopted in October 2007 established the state’s commitments to realizing highest level of reproductive health status, reproductive rights,
access to reproductive health care, safe motherhood and effective interventions to minimize the incidence and effects of STIs and HIV and other morbidities.\textsuperscript{30}

Mounting screening intervention for Syphilis and Cancer of the cervix as a national exercise in Kenya is based on the evidence of their prevalence, severity of harm and potential adverse public health impact. It is estimated that the prevalence of antenatal syphilis in Kenya is 3.8\% and more than half of these develop unfavorable obstetric outcomes, such as maternal deaths, prolonged morbidity and congenital fetal syphilis.\textsuperscript{38,39} Screening for maternal Syphilis early in the first trimester is aimed at minimizing these adverse outcomes and to control spread in the general population. Apparently, few antenatal mothers are likely to benefit from screening since majority of women in Kenya initiate antenatal clinic visits late (at a mean gestation of 5.9 months). Even then, less than one third of receive relevant information and fewer ever obtain blood tests.\textsuperscript{40}

In Kenya, Cervical cancer is the leading cause of reproductive tract cancers. It is associated with high morbidity and mortality burden yet largely preventable.\textsuperscript{5} Consequently, its prevention, early detection through screening and effective management have been prioritized alongside other essential elements by the National Reproductive Health Strategy. The operational guidelines stipulate that providers should take informed consent and document adequate reproductive health history during screening. Additionally, after the procedures results as well as plans for return visits should be discussed with the client.\textsuperscript{25}

\textit{Methodology}

\textbf{Study design and survey instruments}

This qualitative study was conducted in 2010 among clients attending cervical cancer and antenatal clinics in Nyanza Provincial hospital; Kisumu District hospital and Lumumba Municipal health center, all within Kisumu City. The purpose was to explore ethics issues related to both compulsory and voluntary screening from clients’ perspectives. Focus Group Discussions (FGDs) were conducted using interview guides adapted from the ‘Alliance for Cervical Cancer Prevention - Reproductive Health Reports Number 4, July 2001(ACCP)\textsuperscript{41} which contains standard questions for evaluating cervical cancer screening in the developing world.

Discussion points, among other issues, included the participants’ knowledge of the target disease; concerns about developing the disease; perceptions of their own personal risk of Cancer of the cervix or Syphilis and acceptable options for preventions respectively; their motivations to attend screening clinics; disease expectancies (specifically related to their beliefs about the source and consequences of the disease); communicating risk and test results to family members; perceptions, feelings, concerns and experiences during screening either for Syphilis or Cancer of the cervix; repeat tests, privacy, confidentiality and access to services. The FGDs were tape-recorded and supplemented with
back-up observer notes (which captured in summary important relevant issues, such as emotional contents, demeanor and overall ‘feelings’ of the focus group).

**Eligibility and recruitment procedure**

Participants were recruited over three weeks through a two stage process (to minimize potential for coercion). First, the service providers informed their clients about the study. Subsequently, those who were willing to participate in a discussion group were referred (using a study referral note) to the research assistants sitting in a different room. Only females aged at least 18 years and had been tested for Syphilis or undergone cervical cancer screening that day were consented and enrolled. During consenting, everyone was assured of confidentiality and privacy; informed that their voices will be audio-tapped and that they should not use their names during the discussions. Each was assigned a unique number to use during the focus group discussions. Five to eight participants were enrolled sequentially into each focus group. Recruitment was stopped when no new or relevant data seemed to emerge from further interviews. Sixty four women participated in these focus group discussions. Two assistants, a moderator and note taker conducted the group discussions.

Each session lasted about 45 – 60 minutes. Kiswahili (one of the national languages) was the primary language of communication, since majority understood it well. All focus groups were conducted within the facility on the same day participants were recruited. Building consensus on sessions’ ground rules, and conducting the sessions in a secluded place by female research assistants helped particularly to reassure participants. A bottle of soda and biscuits were given to participants during the session. No other compensation was provided. After each session, the research assistants alerted the service provider who then promptly attended to the client in case they were not yet through with any of the clinic procedure such as getting feedback, to avoid further inconvenience.

All regulatory and administrative approvals were granted by the ERC at University of KwaZulu Natal (school of psychology) and Kenya’s National Council for Science and Technology (NCST). Also, relevant authorizing officers from the Ministries of Health headquarters, Provincial administration at the district level, public health department at the Kisumu City council, Nyanza Provincial and Kisumu district hospitals endorsed copies of the approval letters and filed them.

**Analysis**

The moderator for each group transcribed and translated the audio-recordings into English. The first author [DO] reviewed every transcription to confirm accuracy and content validity based on the original audio-recordings. During the translation, we tried to keep the phrases and words as in the spoken language, to capture the context to the extent that is closer to the original language; albeit, we acknowledge that some information and features carried by the local language might be lost when such verbal expressions are translated into English.
Thematic content analysis was performed following Graneheim & Lundman (2004). Data were explored manually using open codes. Participant experiences and views on screening for both Syphilis (compulsory) and Cancer of the cervix (optional) were extracted from the text, condensed and subsequently sorted out by relevant content areas based on the overt and latent emphases as well as their unique experiences and expressions. Conceptual categories related to ethics of screening populations for disease were developed from the resulting themes.
Results
The resulting themes were organised under the following content areas, to reflect emerging ethical issues in screening: lay knowledge and awareness of disease and risks; information-giving at pre-screening and disclosure of results; informed consent for the screening tests; time burden; potential harms during the screening process; acceptance/approval of screening approach.

Knowledge and awareness of disease, risks and prevention.
Participants from either category were well aware of the respective disease conditions, and were able to correctly mention some of their symptoms or outcomes. Overall, majority had received information from the pre-clinical group sessions conducted by medical staff. Other public awareness activities such as posters were considered important sources. Ante-natal mothers considered syphilis as a serious sexually transmitted disease associated with serious adverse effects on pregnancy and warrants prompt attention by individuals and entire communities.

Cancer of the cervix was considered as a serious and ‘disturbing’ condition, probably associated with ‘too much sex’, familial inheritance, poor genital hygiene, smoking cigarettes and previous abortions.

‘If a close relation has this disease, I will feel bad because it is not good in life … I will advise her to go to the doctor quickly before the disease worsens to a condition she cannot walk...it can kill her so she should go to the doctor quickly!’

The women recognized early detection through medical attention, recognition of symptoms and individual sexual behaviour control as being critical to management of both diseases.

‘Before it [Syphilis] is detected, you may not realize you have it; but if you are aware, you can go to the hospital and be treated’
‘… like I had not come for the screening [of cancer of the cervix] and I didn’t know the disease could be detected, so it is advisable to go for screening even before seeing the signs’
‘If you have a genital wound, go to hospital for screening’

Based on their lay knowledge of the diseases, personal experiences and fear of adverse health effects, participants indicated that screening is beneficial to detect diseases early, consequently to plan for appropriate treatment and prevention strategies.

‘Taking control of one’s behavior to protect self after screening; creating awareness among the community members’ about the illnesses; use of condoms and seeking medical treatment promptly were perceived as pragmatic responsibilities for both the individual and whole community.

Perceived advantages and potential harms of Screening.
When asked about what they knew about screening for syphilis, the participants stated that knowing one’s status provides a reasonable basis for making sexual and reproductive health decisions.
‘I know the disease exists and screening helps me in making [a] decision before engaging in sex with a man’

Furthermore, knowing that others have benefited from screening may motivate uptake.

It helps people go for treatment especially when the other people who are reluctant to go will go after they know they are not alone in this’.

On the other hand, reporting positive disease status was deemed frightening. It heightened a sense of fatalism, dejection, worries, agitation and apprehension, hence need for supportive post-screening counseling.

‘If you are tested and not counseled, you can be shocked’

Although there was general confidence about securing the specimen through appropriate labeling, a few were still concerned about potential for getting ‘wrong results’ in case of mix-up in specimen labeling.

‘I am satisfied with the information given after the results because they know your results … when they take your specimen, they label them, hence you are sure the results you get are yours’.

**Information disclosure at pre-screening and post-test period**

**Pre-screening information disclosure**

Pre-screening information disclosure was considered essential for decision-making and minimizing risk of severe emotional consequences that may be associated with the process.

‘If am tested and am not counseled, maybe I can even refuse because it will make me think that these people are assuming I have Syphilis and if am counseled, I can just agree to be tested’

‘I have a better understanding because they test your status and teach you about caring [of your] private parts’.

Additionally, disclosure was necessary to demystify disease causes:

‘Me, I think that I have better understanding than before, because I used to know that cancer is caused by cigarettes, I learnt that the disease is not caused by cigarettes alone it can be inherited from family background and also if you see that it’s in your family lineage its better you go for screening in time so as to know if you don’t have it or if you have it know how you can be helped in time’

A few participants expressed need for prior information about screening to facilitate involvement of spouses / sexual partners:

‘We were not aware of it. It is better if they inform us early so that we can involve our partners instead of being tested alone and my partner is not there’.
Most participants considered pre-screening disclosure helpful but preferred sessions to be interactive, private and confidential. They expected the care-giver to provide sufficient, explicit, simple and clear information in a manner easy to understand.

‘… [T]here is little room for interaction and some talk too fast and clients too many to allow time for discussions … so they want you to give other people room’

However, a few participants were indifferent and others more critical or guarded about the benefit of the disclosures. Expressly, they would be uncomfortable if information about procedures were unclear or when they perceived that care-givers were impersonal and lacked opportunity to engage with them.

‘They didn’t discuss it with us; they just checked the status, so we are blank’

‘It depends on how you find the doctor, how she/he talks to you’.

Some were uncomfortable with certain questions because they seemed intrusive, irrelevant or too complex to understand.

‘I was asked about the last time I gave birth, but I had forgotten since it was a long time ago’

There was a sense of ‘I am doing this because ‘the doctor had said’; I don’t have a choice’. Alternatively, they’d submit because of being already too frail and desperate for help with their symptoms. This reflects challenges in voluntary decision-making when illness is perceived as threatening and opportunities missed to clarify issues.

**Disclosing / Sharing test results and post-test information giving**

Generally, the information given was verbal although routinely the results would be documented in the client’s outpatient card. Written results were considered impersonal if not verbally reinforced. Some participants preferred being attended to by female providers only. Nearly all participants underscored necessity to conduct disclosure privately and ‘with respect, dignity and politely’. They were concerned that sometimes, the staff communicated the test results inappropriately.

‘If results are positive, you should be given guidance and counseling politely and not harshly or by throwing words’

‘I was happy and satisfied because we talked the two of us and no one knew what we had talked about’

Most of the participants discussing cervical cancer screening felt that test results should be released promptly to minimize anxiety, and in a language that is easy to understand. Emotional stress was cited as common regardless of test outcomes.

‘… you should be told about your results immediately instead of waiting, since after the test, when not told you don’t know the results and your heart is not settled’

Consequently, they recommended psychological support with disclosure of results to forestall any psycho-emotional stress. While positive test outcomes confirmed their fears, negative results
confounded them particularly if one already had longstanding overt symptoms. Some of those who obtained negative test results felt that they were not given additional relevant information about the disease and what to do (possibly feeling ignored). Positive test results presented the greatest challenge to handle, because cancer inherently induces fear, anxiety and loss of hope both to self and the family, particularly if results reveal it may already be in advanced stage, whereas further care and support may not be available.

‘If you know your status, you won’t live long. The shock will kill you. So you are better off not knowing’

‘When the nurse told me to lie down to be screened, she said that my case is hard and I had to wait for the other doctor whom she called to check on me. I believe in [G]od; so according to [H]is will so be it; am waiting for the other doctor’

However, some were more optimistic about their post-test care and coping process following the pre-screening disclosure:

‘Mmh, now, if they get us with the disease its good because now I can be given medication, like now I have been told to come on Tuesday to the clinic’.

‘… before getting inside you are told everything, so when you come out of that place it’s you to accept or deny; but me what I see, its good you accept the result, come to terms with the situation and leave things to [G]od and life will not be difficult, but if you live in denial you will shorten your life span and starts to regret that I wish I knew, I would not have gone for this test, and being told about this disease’

**Disclosure of test-outcomes to relatives:**

In discussing whether they would disclose the test results to their spouses or close relatives, it emerged that confidentiality, discretion, intimacy and trust were necessary aspects in disclosing Syphilis test results.

‘It’s better if its I who breaks the news to my husband and not anyone else, because in the hospital we are told the results are confidential’

‘If it’s your husband, it’s okay … because you will be able to plan your life and know how to stay, because you stay together and it’s important that he knows’

Majority of those tested for cancer of the cervix preferred to personally divulge their test status to close relatives for reassurance, planning family prospects or eliciting social support, depending on their perspective of prevailing family context.

‘I will prefer to be the one to tell them since I know how they are. Some may be shocked and distressed’.
**Informed consent**

Opinions were varied about submitting to screening for Syphilis during antenatal visits and whether the information should be written or just verbal. Written consent was considered necessary to authenticate decisions, clinic visits and specify tests to significant others. However, simultaneous multiple clinical tests confounded the context for informed consent specific for Syphilis. While a number of respondents were aware certain antenatal tests including for Syphilis was mandatory, few were ready for them while some felt providers ‘pushed’ them into it and others were ambivalent.

‘It is a disease that must be screened for during pregnancy, so if you are free you just come, you don’t wait to be told’;

‘I had made a decision to be tested before I got pregnant, but at the clinic I was told it is a must’.

‘We were told it is a rule to undergo the test … even if you did not come for the screening’

‘I have two minds. One, it is good since the disease is treatable. Two, I feel stressed, because I will be asking myself – where did I get it from’.

Nevertheless, there was broad consensus that ‘informed consent’ process if conducted in privacy, accords the clients an opportunity to clarify their positions before opting for the test procedures. Participants indicated need to clearly understand the test processes and prospects, without being coerced or handled in a manner that may impair personal judgment, given that decision-making is a complex affair.

Of the participants discussing screening for cancer of the cervix, a few felt they were ‘pushed’ by poor health to take the tests. Their concept of a ‘meaningful informed consent’ encompassed sufficient information disclosure about procedures; understanding given information; confidentiality and ‘trust’ in the caregivers (particularly those familiar to them) not to divulge personal details; interactive rapport with the care-giver; and a ‘welcoming’ environment. ‘Sufficient information’ entails ‘thorough explanations’ that meets the needs of every client. They indicated these needs may vary depending on health status and the anticipated test-outcomes. This portends the challenges staff face to ensure client autonomy while implementing guidelines.

**Time and cost burden**

Most of the participants felt the waiting time before getting results was too long, sometimes running to a whole day or several weeks, for cervical cancer screening. This further heightened their anxieties as well as discouraging them from coming back to the clinic for follow up. Majority of women coming for screening of cancer of the cervix had travelled from far. Some reported the process was complicated and took long to complete. Lack of money to pay for some of the services and / or travelling (cost factor) further complicated their choices for the screening services.
Experiences during test procedures

Overall, participants highlighted diverse experiences and feelings. On a positive note, some of them felt accepted and appreciated during the process, conferring a sense of relief about results and expectation to get effective treatment. Participants who initiated screening felt more confident the services were helpful. Nevertheless, others experienced worries, despondence and sadness. Also the fear of pain or discomfort during finger pricking or pelvic examination; sense of embarrassment undressing before a male care provider for pelvic exam to confirm genital lesions and discussing personal sexual relations and experiences were elicited as important challenges.

‘At first I felt embarrassed when the [male] doctor told me to undress and climb up the couch [to be done vaginal exam]; but the doctor talked well and urged me to be open so as to be helped’.

Adverse perceptions or experiences during screening were reportedly the reasons some women opted instead to seek alternative care from traditional midwives who do not perform screening. It emerged that those who ‘don’t know their status’ and don’t attend clinic were likely to influence others against screening.

Necessity and acceptability of repeat tests and follow-up visits:

There were varied perceptions about follow-up or repeat examinations. While some appreciated that it may be necessary, in case of missed detection at the initial visit, others were not convinced of its value.

‘I can just go back if required because I don’t know why and just in case I have the disease but it was not detected at initial screening, so its good to know what is happening’

‘I can just go but asking myself “but I had already undergone the test; why are they telling me to repeat it?” May be I got it from somewhere!’

‘I will not accept [repeat tests] because she tested me the first time. Is it that she didn’t get it? I am not at ease since it’s already tested …’

‘I can’t be happy because the initial results were bad. So I can’t be sure of my life’

‘It would be difficult if [I] am going to spend the same time waiting for results’

Regarding follow-up visits participants’ concerns were: long waiting-time, lack of coping skills or psychosocial support for those who test positive due to insufficient community awareness and potential for stigma due to disease association with sexuality. These may reinforce a notion of ‘helplessness’ and contribute to reluctance to comply with follow-up visits among those who test positive.
**Discussion**

Understanding ethical perspectives of health interventions is necessary to address the diverse aspects which may create or exacerbate ethical problems. In Kenya the prevalence of Syphilis is relatively low, yet adverse effects are considerable.\(^{38,43}\) Syphilis screening is part of the national prevention and control efforts to mitigate its spread in the population and eliminate congenital types. Similarly, the goal of systematic screening of cervical cancer is to reduce incidence and mortality through early detection of precancerous lesions and invasive cancer and determining appropriate management. The participants’ perspectives of screening for both Syphilis and Cancer of the cervix as elicited from this study provide a contextual platform to frame related ethics issues. Both conditions were considered serious to warrant early detection and treatment. Whereas screening was considered beneficial, ethical issues elicited related to potential harms associated with its conduct, some of which could be mitigated by appropriate communication.

**Pre-screening information disclosure**

According to the responsibility criterion, the health provider ought to notify clients of a mandatory public health intervention, its rationale and procedures involved and options.\(^{44}\) This is necessary, especially in potentially coercive activities, to complement client’s autonomy, gain their trust and enjoin them in decision-making to protect their interest.\(^{44}\) Screening process involved registration at the initial encounter, pre-screening health talk; conducting tests; communicating results and invitation to follow-up visits. Adopting simple interactive discourse during the process can enhance the disclosure process.\(^{45}\) Providing satisfactory information in terms of its intensity; simplicity and relevance, can help in de-stigmatizing the diseases by illuminating lay understanding, clarifying notions and shaping decision intentions for on-going participation in the screening programs.\(^{46}\) From this study the participants desired to see staff being respectful and sensitive to their unique contexts, preferences, values and expectations albeit varied. This indicates need for providers to appreciate participants’ value preferences during screening.

**Decision-making and participation in screening**

Women participating in this study had reasonable lay understanding of syphilis and cervical cancer and the possibilities for their early detection and treatment. Their choice for screening was influenced by individuals’ lay knowledge; community biases; sense of personal moral obligations; pre-screening education; pregnancy status; health status and expectations to benefit from disease identification and informed intervention choices; and compulsoriness of the procedure. This indicates the general context for participation in screening in this region. The women valued voluntary participation in either screening approach. However, this remains a subtle issue given the nuances in the context of inherent inequities in health service provision.\(^{27}\)
Decisional autonomy, perceived as a complex concept is associated with multiple interposing effects of diverse issues such as social preferences and relationships, level of dialogue, time burden, tests required and individual idiosyncrasies.\textsuperscript{47,48} Participants undergoing compulsory screening (for Syphilis) believed their spouses should be involved to minimize prejudice related to a positive test status, enhance choices and disclosure. Hence it may be seen as a ‘corporate’ exercise and/or with someone else’s preference as a reference point.

Interactive communication provides opportunities to clarify concerns and promote peer decision support in risk comprehension among participants.\textsuperscript{49} Conceivably, the participants’ experiential views or lay knowledge of the target diseases influenced their perceived need for and expectancies of screening, similar to Croyle and Lerman’s (1999) who observed that clients’ decision to seek or accept genetic tests and whether they would recommend it to their kinfolk was informed by their perception of risk.\textsuperscript{50}

One of the likely sources of ethical tension in implementing screening programs is the balance between respect for personal rights versus restricting individual liberties for the common good. For example, the health provider may be confronted with a dilemma in responding to an ambivalent client or one who cedes her decision-making to the care-giver despite candid information sharing. Participants’ complaints of coercion demonstrates the inherent challenges on how to resolve competing demands between fulfilling client preferences (personal dignity) and professional obligations to minimizing public health risks (paternalism)\textsuperscript{45,47,51}. Some of the participants in this study ‘trusted’ that a medically–trained staff, would make ‘expert’s’ decision in their best interest (reasonable standards criteria). This could raise the ethical concerns of coercion and paternalism by the clinician or alternately lack of client voluntarism or significant autonomy. Frequently, this position is reinforced by the power balance in favour of the service provider\textsuperscript{52} as well as the clients’ perceived vulnerability or apparent helplessness towards diseases viewed as severe, painful, disturbing or dangerous.

Potential conflict exist between regulatory requirement for mandatory disease control through diagnosis, treatment, notification and sufficient follow up/surveillance of Syphilis sero-positive cases and their partners\textsuperscript{5,32,38,53} versus the concern for confidentiality and client autonomy. The Care-giver may find observing the legal requirements challenging considering the prescribed penalty for failed adherence. Primarily, the staff should rely on their moral and professional codes plus existing guidelines to decide on the individual cases. Literature on screening shows that client’s on-going participation in screening can be augmented through effective communication strategies.\textsuperscript{54,55} Hence, providers can maximize their encounters through use of communication aids to reinforce peer group health education,\textsuperscript{54,55} encouraging relevant choices and protecting privacy and confidentiality.\textsuperscript{56}
Pain, psycho-emotional and social harms associated with screening

The potential to feel pain, a measure of physical or emotional discomfort, and fear of being stigmatized due to screening procedures or test status requires a delicate balance between the health needs within the prevailing contexts versus the goals of the screening exercise. The ethical requirement is to have and comply with guidelines, which should be comprehensive and displayed for ease of reference for pre- and post-screening counseling besides providing relevant training and regular updates for the staff involved.

At the policy level, more stringent considerations are required to minimize potential infringement and harm in case individuals plus their families are identified as being at increased risk. Kass (2004), has proposed consideration of the following criteria for ethical health policy: (i) publication of the surveillance data should create proportionate opportunities to appropriately resource interventions to populations with the highest disease burden, in this case cancer of the cervix and syphilis; (ii) Simultaneous considerations for social acceptability of procedures versus the number needed to screen to prevent one case of the disease should be made given the potential impact on service uptake and cost effectiveness; (iii) The contextual level of public health necessity for implementing this form of screening approach on a wider scale should be defined a priori, based on the prevalence and resource availability for care and management. In Kenya, compulsory antenatal screening for Syphilis is justifiable because consequential congenital syphilis and maternal morbidity are prevalent but can be eliminated. Concerning, Cancer of the cervix its high incidence among HIV sero-positive women is a public health issue and the net benefit from the screening exercise is worth considering.

Both Syphilis and Cervical cancer are associated with sex and reproduction. Social status may be harmed by positive results due to loss of personal and social esteem, stigma, anxiety and fetal loss, among others. Surveillance and notification as part of screening are necessary in identifying proportionate distributions of disease burden in populations, and level of prevention and care resources required. Accordingly, the ‘compelling’ governmental interests in reproductive and sexually related disease control should be elucidated and delineated in the health policy and other guidelines. This would clarify the degree of infringement of prescribed human liberties as well as broad and specific public health goals.

The current study has revealed real harms exist. However, effectiveness of the screening approaches vis-à-vis the harms still require further evaluation. Also, strict rationale, fairness and high level of transparency in decision-making or disclosing information as well as negotiating issues of privacy and confidentiality are essential to ensure public trust and effectiveness when executing screening services for these two conditions. An important consideration is that the disclosed
information should bear a reasonable connection to the purpose of the interventions and procedures employed in simple language.

**Time burden**

Time burden (as a hidden cost) constitutes the period that clients have to spend going through the entire process of screening, including disclosure of results. Prolonged waiting time may potentiate uncertainty or exacerbate clients’ existing apprehensions especially when no adequate preparation or information is provided. Also, time could be experienced as problematic for clients, when limited or lacking, possibly reinforcing their perception of care as impersonal and insecure, hence need to seek alternatives, and for providers to be more sensitive. Prolonged travel and waiting time as well as costs charged were barriers to uptake of screening services as they augment the time burden incurred by clients.

**Conclusions**

The context for mounting screening as a public health intervention and attendant ethical issues may be more complex than hitherto perceived. Interpreting emerging ethics issues in screening requires more nuanced considerations of individuals’ mundane experiences that are innately intertwined with their traditional and contemporary lore. It is apparent that in considering mounting screening for Syphilis and cervical cancer, the community interests and perspectives may be at variance with that of the national health regulatory and policy frameworks. For example, issues of acceptability of a specific procedure may complicate its micro-availability (as a distributive concept) because it requires conformity to or cooperation with the social norms. Besides, clients may lose opportunities to clarify their concerns at the service interface, perhaps for fear of retribution or communication lapse whereas the staff may also fail to elicit and mitigate adverse personal or group experiences during such interactions, hence tensions between voluntarism and paternalism in screening may be reinforced. Lack of information may further influence adversely the demand for screening services by the individuals at risk or the community as a collective agent. However, appropriate health education techniques, meaningful engagement with community members and inculcating the relevant emerging qualitative indigenous information into the process is more likely to improve intended screening outcomes. Similarly, attention should focus on the perspectives from unapparent populations which may potentially influence social behavior.

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